

## ASSIGNMENT OF BENEFITS

My signature below indicates that I understand and agree that my physician ordered the oximetry test just taken for the purpose of verifying my need for home oxygen in relation to my pulmonary disease. Further, I hereby authorize and release **Protecs Labs**, an independent testing and diagnostic facility, to bill my insurance carrier(s) and/or Medicare on my behalf for the costs associated with this testing. I understand that I may be financially responsible for any deductibles and/or copay amounts, and agree to make such payment if it is determined that either has not been met at the time of billing. I authorize **Protecs Labs**, to release information concerning this test and any medical information necessary to inform the provider(s) of my medical care of results of testing.

## MEDICAL RELEASE

I \_\_\_\_\_ (Patient's Name) \_\_\_\_\_ (Address) hereby release my medical record, which contains oximetry results to my prescribing physician. I also release my medical record to the home care provider listed below. My signature on this form gives the right to release these test results to the company/person listed below.

Information to be released to:

\_\_\_\_\_  
Company/Individual Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
Fax

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

## DIARY OF ACTIVITIES

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PERFORMED ON: \_\_\_\_\_ ROOM AIR or \_\_\_\_\_ OXYGEN @ \_\_\_\_\_ LPM  
\_\_\_\_\_ CPAP/BiPap \_\_\_\_\_ cmH<sub>2</sub>O  
\_\_\_\_\_ Other \_\_\_\_\_

TIME	( Circle One)	ACTIVITY DESCRIPTION
_____:____	AM OR PM	Time Test Started
_____:____	AM OR PM	_____
_____:____	AM OR PM	_____
_____:____	AM OR PM	_____
_____:____	AM OR PM	_____
_____:____	AM OR PM	_____
_____:____	AM OR PM	_____
_____:____	AM OR PM	Time Test Ended

## STATEMENT OF AUTHENTICITY

By signing below, I certify that I am the recipient of the oximetry testing and that the test was actually performed on me. The provider verified my identity. I also certify that neither I nor the provider of this test has tampered with or altered this test in any way and that it will be downloaded in its original form.

\_\_\_\_\_  
**Oximeter Serial Number**

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date